October 3, 2002

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2-02-1156-01
IRO #: 5251

___has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed MD with a specializing and board certified in Orthopedic Surgery. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___ is a 43-year-old woman who injured her lower back on ___ when she was employed at ___ as a manager. On the day of injury she was standing on a chair writing on a board when the chair broke, causing her to fall on her feet. She heard a large pop in her lower back. She was unable to walk after that.

This patient was seen at ___ emergency room where she was treated with medications. She had a MRI of the lumbar spine and x-rays. She followed up with ___ who treated her with pain medicine, muscle relaxers. He prescribed physical therapy.

___ never had any problems with her back or legs prior to this incident. She has had a MRI of the lumbar spine which demonstrated degenerative changes at L4-L5 and L5-S1. She has also had a discogram with a CT scan that demonstrates moderate degenerative changes at L5-S1 with moderate annular bulging.

This patient has had exhaustive conservative non-surgical treatment to include physical therapy, anti-inflammatory medicine, intra-muscular steroid injections, lumbar epidural steroid injections (2x), prescription narcotics and muscle relaxers with no resolution of her symptoms.

Since May of 2002, ___ has been off work. She is complaining of persistent lower back pain and bilateral leg pain. This patient has been seen by ___at the ___, and he has recommended transverse interbody fusion. Her physical examination demonstrates there are no Waddell signs. She is having tenderness over L5-S1 sciatic notches. Forward flexion causes buttocks pain. She has mildly positive straight leg raises at 50 degrees, negative on the left. Her motor strength is 5/5 throughout her lower extremities. Her reflexes are +2/4 equally and bilaterally. She has been given a diagnosis of degenerative disc disease of the lumbar spine mechanical back pain and bilateral sciatic pain, right greater than left.

REQUESTED SERVICE

Transverse lumbar interbody fusion with Arthrodesis under microscope

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

This patient does meet the criteria for transverse interbody fusion as proposed by ___. This decision is based on the fact that the patient has exhausted all non-operative reasonable treatment to address her chronic low back pain and bilateral sciatic pain. There are ample diagnostic studies (MRI of the lumbar spine, CT/discogram) which seem to demonstrate an L5-S1 discogenic pain generator. The patient has undergone lumbar epidural steroid injections without relief. Given this information, treatment guidelines and care standards would suggest a L5-S1 interbody fusion of some type.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TDI/TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).